MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7584 (7584)

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carrell
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 121 Main St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
NETTIE	VIOLA	BAIRD	August	4	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W	Married	October 25, 1891	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Sorter	Laundry	Maryland	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Christopher Fields	Carolyn Regan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Mrs. Irma Harper 603 Linnard St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 181X Cancer of the bladder — INTERVAL BETWEEN ONSET AND DEATH: 6 mo. (?)

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
			M.		

22. I hereby certify that I attended the deceased from June 26, 19 55, to Aug. 4, 19 55, that I last saw the deceased alive on Aug. 3, 19 55, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE James T. Marsh (DEGREE OR TITLE) M.D. ADDRESS Westminster Md DATE SIGNED Aug 4/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 8 1955	Meadowridge Mem. Pk.	Elkridge, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
August 6, 1955	R. W.	John F. Denny, Inc.	715 Light St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07585

7587 **CERTIFICATE OF DEATH** Reg. Dist. No. 78

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - near Taylorsville
LENGTH OF STAY (in this place) 6 1/2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Route 1 - New Windsor

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - near Taylorsville X
STREET ADDRESS (If rural give location) Route 1 - New Windsor

3. NAME OF DECEASED: (First) Reuben (Middle) Henry (Last) Baker

4. DATE OF DEATH: (Month) August (Day) 25 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: June 28, 1898

9. AGE last birthday: 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Reuben Sidwill Baker

14. MOTHER'S MAIDEN NAME: Mary Catherine Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-24-8073

17. INFORMANT & ADDRESS: Ruth Emily Smith Route 1 - New Windsor Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 023X
(A) Luetic Aortitis with Decompensation — INTERVAL BETWEEN ONSET AND DEATH: More than 3 years

ANTECEDENT CAUSE (S)
DUE TO
(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1953, to August, 1955, that I last saw the deceased alive on August 4, 1955, and that death occurred at 7 A. M, from the causes and on the date stated above.

SIGNATURE W B Culwell M. D. ADDRESS Mt. Airy, Md DATE SIGNED Aug. 25, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug 27-1955
NAME OF CEMETERY OR CREMATORY Taylorsville Cem.
LOCATION (City, town, or county) (State) Taylorsville Maryland

DATE REC'D BY LOCAL REGISTRAR 8-25-55
REGISTRAR'S SIGNATURE E. M. Farver

24. FUNERAL DIRECTOR D D Hartzler & Sons ADDRESS New Windsor Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07586

7588 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 2/13/46
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 Vol-4
STREET ADDRESS (If rural give location) 2901 Ailsa Avenue

3. NAME OF DECEASED: (Type or Print) (First) Norman (Middle) Allen (Last) BANDEL

4. DATE OF DEATH: (Month) August (Day) 8 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: September 3, 1891
9. AGE last birthday 63 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Collector
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): United States
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GeorgeBandel
14. MOTHER'S MAIDEN NAME: Sallie Bruscup

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
025X IMMEDIATE CAUSE	(A) Bronchopneumonia	5 days
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) General paresis	9 yrs.
	DUE TO	
	(C) Syphilis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Psychosis with syphilitic menin-co-encephalitis	More than 7 yrs.

19A. DATE OF OPERATION: ---
19B. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) --- M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Aug. 24, 1948, to Aug. 7, 1955, that I last saw the deceased alive on Aug. 7, 1955, and that death occurred at 1:50 A M, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. ADDRESS Martin Gross, M. D. M. D. Sykesville, Md. DATE SIGNED 8/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-10-55
NAME OF CEMETERY OR CREMATORY Baltimore
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 8, 1955
REGISTRAR'S SIGNATURE C. Harry Tucker
24. FUNERAL DIRECTOR J. Henderson - North & Broadway - Balto
ADDRESS

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07587

7589

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X rural--Sykesville
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: oo

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural--Sykesville X
STREET ADDRESS (If rural, give location): Gist /

3. NAME OF DECEASED (Type or Print): (First) EMIL (Middle) O (Last) BARNES

4. DATE OF DEATH: (Month) AUG. (Day) 23 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 9-11-1881

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer retired

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John T. Barnes

14. MOTHER'S MAIDEN NAME: Caroline Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-18-8760

17. INFORMANT AND ADDRESS: Mrs. Gertie Barnes, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) cerebral hemorrhage — Interval Between Onset and Death: 2 weeks

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis — 5 or 6 yrs

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1955, to 8/23/, 1955, that I last saw the deceased alive on Aug. 22, 1955, and that death occurred at 11 30 A.m., from the causes and on the date stated above.

SIGNATURE: Lee Wolbens M.D. (Degree or title) ADDRESS: Westminster DATE SIGNED: 8/23/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE: 8-26-1955

NAME OF CEMETERY ~~OR CREMATORY~~: Bethesda

LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE REC'D BY LOCAL REG.: Aug 25-1955

REGISTRAR'S SIGNATURE: Robert B. Hewitt

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Maryland — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07588

7590 **CERTIFICATE OF DEATH** Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1 y 11 m 13 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfiedd State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 13 3V01-4
STREET ADDRESS (If rural give location) 1719 N.Port Street √

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) C. (Last) Burton
4. DATE OF DEATH: (Month) 8 (Day) 28 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 1 - 16 - 70
9. AGE last birthday 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William S. Arnold
14. MOTHER'S MAIDEN NAME: Anna V. Younger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1
IMMEDIATE CAUSE (A) Cerebral hemorrhage — days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic cardiovascular disease — years
DUE TO
(C) Genaralized Arteriosclerosis — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Chr.brain syndr.ass.with senile brain dis. with psych. reactions — years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 - 18 - , 1955, to 8 - 27 - 1955, that I last saw the deceased alive on 8 - 27 - , 1955, and that death occurred at 1:00 AM, from the causes and on the date stated above.
SIGNATURE Edmund Lusthaus M.D. ADDRESS Springfield State Hospital DATE SIGNED 8 - 28 - 55
Edmund Lusthaus

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug. 31, 1955
NAME OF CEMETERY OR CREMATORY Foster Cemetery
LOCATION (City, town, or county) (State) Hereford, Maryland

DATE REC'D BY LOCAL REGISTRAR 8-29-55
REGISTRAR'S SIGNATURE W. Hedrick
24. FUNERAL DIRECTOR ADDRESS Wm J. Tickner & Sons, Balto, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07589

CERTIFICATE OF DEATH

7591

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Henryton
LENGTH OF STAY (in this place): 30 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 3Y01-4
STREET ADDRESS (If rural give location): 3006 Harlem Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) Frederick (Last) Caulk
4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 3-17-1896
9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Janitor
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ellis Hall
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes (If Yes, give war or dates of service): I
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Carrie Johnson, 3006 Harlem Avenue

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

002x
Immediate cause (a) Far advanced bilateral cavitary tuberculosis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-5- ,1955, to 8-4- ,1955, that I last saw the deceased alive on 8-4-, 1955, and that death occurred at 6:05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): J.F. Cook M.D
ADDRESS: Henryton, Maryland
DATE SIGNED: 8-4-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 8-8-55
NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
LOCATION (City, town, or county) (State): Brooklyn Md

DATE REC'D BY LOCAL REGISTRAR: 8-4-55
REGISTRAR'S SIGNATURE: Albert R Swanstrand
24. FUNERAL DIRECTOR: Edwyn O. Wilson
ADDRESS: 1044 Brooklyn Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07590

7592

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 5 Mos. 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring 15-54-2
STREET ADDRESS (If rural give location) 10403 Huntley Avenue ✓

3. NAME OF DECEASED. (Type or Print) (First) William (Middle) Henry (Last) CONWELL

4. DATE OF DEATH: (Month) 8 (Day) 18 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 1/1/78

9. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Sash

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Conwell

14. MOTHER'S MAIDEN NAME: Sarah Allgood Conwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (B) DUE TO Bronchopneumonia — 5 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic Brain Syndrome associated with Cerebral arteriosclerosis, wit. psycotic — 2 years?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13, 1955 to 8/18, 1955 that I last saw the deceased alive on 8/18, 1955, and that death occurred at 9:30 PM, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt M.D. ADDRESS Sykesville, Maryland DATE SIGNED 8/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 8/22/55 — NAME OF CEMETERY OR CREMATORY Fort Lincoln — LOCATION (City, town, or county) (State) Colmar Manor, Md

DATE REC'D BY LOCAL REGISTRAR 8/19/55 — REGISTRAR'S SIGNATURE C. Harry Weed

24. FUNERAL DIRECTOR — ADDRESS F. Rascha Sons Hyattsville Md

07591

7593

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Taneytown — LENGTH OF STAY (in this place): Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS: (D)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Taneytown X
STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print): (First) Jennie (Middle) K. (Last) Copenhaver

4. DATE OF DEATH: (Month) (Day) (Year): August 21, 1955 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12/20/1872

9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Haifley

14. MOTHER'S MAIDEN NAME: Clarissa Stonesifer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: William M. Copenhaver, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic myocarditis – myocardial degeneration.	10 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	10 yrs
	(c) Cerebral arteriosclerosis	10 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Debility, Senile

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-5 , 1946, to 8-21-, 1955, that I last saw the deceased alive on 8-20, 1955, and that death occurred at 11:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) E. Ambler Thompson — ADDRESS Taneytown, Md. — DATE SIGNED 8-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug. 24, 1955 — NAME OF CEMETERY OR CREMATORY: United Bretheran Cemetery — LOCATION (City, town, or county) (State): Taneytown, Maryland

DATE REC'D BY LOCAL REG.: August 24, 1955 — REGISTRAR'S SIGNATURE: Ethel M Mehring Local

24. FUNERAL DIRECTOR — ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ... especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8537

CERTIFICATE OF DEATH

08540

Reg. Dist. No. ... ..

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) more than 41 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN not known 11X-2
STREET ADDRESS (If rural give location) Not known ✓

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) (Last) Davis

4. DATE OF DEATH: (Month) 8 (Day) 31 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single
8. DATE OF BIRTH: 2 2 1889
9. AGE last birthday 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Garrett County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Davis
14. MOTHER'S MAIDEN NAME: Catherine Bray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

421X
IMMEDIATE CAUSE (A) Bronchopneumonia — 2 days
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Epithelioma of skin with metastasis, unknown 47 yr
Convulsive disorder with psychosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1954 to Aug 31, 1955 that I last saw the deceased alive on August 31, 1955, and that death occurred at 7:10 P.M., from the causes and on the date stated above.
SIGNATURE Walther H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 9/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL
DATE THEREOF SEPT 12 1955
NAME OF CEMETERY OR CREMATORY U of M MEDICAL SCHOOL
LOCATION (City, town, or county) (State) 29 S GREEN ST MD

DATE REC'D BY LOCAL REGISTRAR Sept. 13, 1955
REGISTRAR'S SIGNATURE C. Harry Fuss
24. FUNERAL DIRECTOR Duffel Bro
ADDRESS 1800 E LOMBARD ST

(Correct age is especially important.)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07592

7594 CERTIFICATE OF DEATH Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Henryton
LENGTH OF STAY (in this place): 121 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1634 N. Smallwood Street

3. NAME OF DECEASED: (Type or Print) (First) Susie (Middle) Rebecca (Last) Dawson

4. DATE OF DEATH: (Month) 8 (Day) 21 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 12-4-1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private Home

11. BIRTHPLACE (State or foreign country): Lancaster, Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Edgar Smith

14. MOTHER'S MAIDEN NAME: Elizabeth Thornton

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Susie R. Dawson - 1634 N. Smallwood Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

012.0
Immediate cause (a) Tuberculosis of the thoracic Spine
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY ? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 4-22-, 1955, to 8-21-, 1955, that I last saw the deceased alive on 8-21-1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): T.F. Leopal M.D
ADDRESS: Henryton, Maryland
DATE SIGNED: 8-21-55

23. BURIAL, CREMATION, REMOVAL (Specify): Buriel
DATE THEREOF: 8-25-55
NAME OF CEMETERY OR CREMATORY: Family Lot
LOCATION (City, town, or county) (State): Whitestone, Virginia

DATE REC'D BY LOCAL REGISTRAR: 8-21-55
REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07593

7595 CERTIFICATE OF DEATH Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg
STREET ADDRESS (If rural give location) Rural

3. NAME OF DECEASED: (First) SAMUEL (Middle) EMORY (Last) DIEHL

4. DATE OF DEATH: (Month) Aug. (Day) 29 (Year) 1955

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower | 8. DATE OF BIRTH: 9/30/1867 | 9. AGE last birthday: 87 yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William S. Diehl

14. MOTHER'S MAIDEN NAME: Teresa —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO: none

17. INFORMANT & ADDRESS: Mary F. Harbaugh, Middleburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) DUE TO: Cerebral Hemorrhage

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO: Arteriosclerosis
(c) Senile Debility

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1955, to Aug. 29, 1955, that I last saw the deceased alive on Aug. 25, 1955, and that death occurred at 5 a.m. from the causes and on the date stated above.

SIGNATURE J. F. Brown, M.D. (Degree or title) ADDRESS Union Bridge, Md. DATE SIGNED Aug 29

23. BURIAL, CREMATION, REMOVAL (Specify) Buried | DATE THEREOF 8/31/55 | NAME OF CEMETERY OR CREMATORY Ridge Church Cem. | LOCATION (City, town or county) Union Bridge | (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 30, 1955 | REGISTRAR'S SIGNATURE Leslie L. Riffle

24. FUNERAL DIRECTOR D. D. Harman & Son | ADDRESS Union Bridge, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

M

MARYLAND STATE DEPARTMENT OF HEALTH

7596

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07594

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lineboro — LENGTH OF STAY (in this place) Permanent HOSPITAL OR INSTITUTION OR STREET ADDRESS	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Carroll CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead STREET ADDRESS (If rural, give location) R.F.D. (Trapple Grove)
3. NAME OF DECEASED (Type or Print) (First) Ray (Middle) Earl (Last) Duibs	4. DATE OF DEATH (Month) Aug (Day) 21 (Year) 1955
5. SEX M — 6. COLOR OR RACE W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH Oct 10-1940 — 9. AGE last birthday 14 yrs. — If under 1 year: Months, Days — If under 24 hrs: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student — 10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John L. Duibs	14. MOTHER'S MAIDEN NAME Elizabeth M. Hilker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — 16 SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS John L. Duibs Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

929.9

Immediate cause (a) Drowning

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [illegible] — (CITY OR TOWN) Lineboro (COUNTY) Carroll (STATE) Md

TIME OF INJURY (Month) 8 (Day) 21 (Year) 55 (Hour) 7 P m. — INJURY OCCURRED While at work ☐ Not while at work ☒ — HOW DID INJURY OCCUR? Drowned

22. *I certify that I took charge of the remains described above, held an Autopsy* _, *Inspection* ✓ *Inquiry* ✓ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE [illegible] (Degree or title) Deputy Med Examiner ADDRESS Westminster Md DATE SIGNED 8/21/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8/24/55	Lazarus Union	Lineboro	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
Aug 22/55	Mrs. F. R. Sdeour B	H. Reifsnider & Son	Glen Rock Pa

H. Reifsnider

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07595

7597 CERTIFICATE OF DEATH Reg. Dist. No. 36

1 PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN X Rural, Westminster
LENGTH OF STAY (In this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Winters Building Home, Dagmary Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster X
STREET ADDRESS (If rural give location) Spring Mills

3. NAME OF DECEASED: (First) ROBERT (Middle) F (Last) FRANKLIN
4. DATE OF DEATH: (Month) Aug. (Day) 4 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M.	White Male	Single	?	88 yrs.			

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Franklin
14. MOTHER'S MAIDEN NAME: Mary Reese

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Harvey L. Ramsie, Westminster Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause 424.2 (a) Myocarditis (Coloid) DUE TO Nephritis (Chronic)
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cardiac Arthma DUE TO
(c)
Interval Between Onset And Death: 10 yrs.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1955, to Aug. 4, 1955, that I last saw the deceased alive on Aug 3, 1955, and that death occurred at 8 am., from the causes and on the date stated above.
SIGNATURE (Degree or title) W. C. Jeanette M.D.
ADDRESS Westminster Md
DATE SIGNED Aug 4-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug. 6-55
NAME OF CEMETERY OR CREMATORY Baltimore Cemetery
LOCATION (City, town, or county) Rural, Westminster (State)
DATE REC'D BY LOCAL REGISTRAR 8-4-55
REGISTRAR'S SIGNATURE Hazel Wolfe
24. FUNERAL DIRECTOR J. E. Myers Jr.
ADDRESS Westminster Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

AuG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07596

7598 CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (In this place) 18 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 568 Balto. Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural give location) 568 Balto. Blvd

3. NAME OF DECEASED: (Type or Print) (First) NATHAN (Middle) WARNER (Last) GILLETTE

4. DATE OF DEATH: (Month) Aug. (Day) 31 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 26 1896

9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Industrial engineer

10b. KIND OF BUSINESS OR INDUSTRY: Sylvania Corp.

11. BIRTHPLACE (State or foreign country): Boston Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rev. Wallace Gillette

14. MOTHER'S MAIDEN NAME: Harriett Hawthorne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) World War I.

16. SOCIAL SECURITY No.: 013-05-1493

17. INFORMANT & ADDRESS: Mrs. Potter W. Gillette, Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 452.1
(a) Coronary Thrombosis — Interval Between Onset And Death: Instant

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO
(b) Coronary Sclerosis — 1946
DUE TO
(c) Coronary Thrombosis — Prob. 10 yrs.
DUE TO
(c) Arteriosclerosis & Hypertension

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1955, to Aug 31, 1955, that I last saw the deceased alive on Sept 1, 1955, and that death occurred at 10:00 P.M., Aug 31-55, from the causes and on the date stated above.
SIGNATURE (Degree or title) Wilbur Specht ADDRESS Westminster Md DATE SIGNED 9-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation DATE THEREOF Sept. 5, 55 NAME OF CEMETERY OR CREMATORY Loudon Park LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECD BY LOCAL REGISTRAR 9-2-55 REGISTRAR'S SIGNATURE Hamet Miller

24. FUNERAL DIRECTOR J. E. Myers Jr. ADDRESS Westminster Md

VS. A11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7593 CERTIFICATE OF DEATH

07597

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 4 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadowview Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster R. D. 3
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) MARGARET (Last) GREEN

4. DATE OF DEATH: (Month) August (Day) 29 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan. 14, 1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Plee

14. MOTHER'S MAIDEN NAME: Mary Onitz

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Herman F. Green 109 E. Main Westminster, Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
42.14 Immediate cause	(a) Coronary Thrombosis	15 min
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Arteriosclerosis Coronary Sclerosis	3 yrs
	DUE TO (c) Arthritis multiple Hypertensive Heart Disease	5 yrs 10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1949, to August 29 1955, that I last saw the deceased alive on Aug. 29, 1955, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

SIGNATURE William Speicher (Degree or title) Md ADDRESS Westminster Md DATE SIGNED 8/31/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept. 1 1955 NAME OF CEMETERY OR CREMATORY Westminster Cemetery LOCATION (City, town, or county) (State) Church St. Westminster Md

DATE REC'D BY LOCAL REGISTRAR 9-1-55 REGISTRAR'S SIGNATURE Hamet Miller

24. FUNERAL DIRECTOR H. Bankard & Son ADDRESS Westminster Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

76 0

CERTIFICATE OF DEATH

07598

Reg. Dist. No. 82-83

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X West Hny – Rural
LENGTH OF STAY (in this place) 48 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural – Mt. Airy X
STREET ADDRESS (If rural give location) Near – Woodbine

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Maurice (Last) Hess

4. DATE OF DEATH: (Month) Aug (Day) 7 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH: Feb 2. 1879

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10B. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Taneytown, Maryland

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Samuel Francis Hess

14. MOTHER'S MAIDEN NAME: Priscilla Rebecca Bushey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. Daisy M. Hess, Same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE	(A) Cerebral hemorrhage, arteriosclerosis	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) hypertension, cardiac arrest	
	DUE TO (C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 Aug, 1955, to 7 Aug, 1955, that I last saw the deceased alive on 7 Aug, 1955, and that death occurred at 9:30 PM, from the causes and on the date stated above.

SIGNATURE Howard E Hess M. D. ADDRESS Hyattsville, Md. DATE SIGNED 9 Aug 55

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial

DATE THEREOF 8-11-1955

NAME OF CEMETERY OR CREMATORY Mt. Olivet

LOCATION (City, town, or county) (State) Frederick, Md.

DATE REC'D BY LOCAL REGISTRAR Aug 10-55

REGISTRAR'S SIGNATURE Robert R. Hewitt.

24. FUNERAL DIRECTOR C. M. Waltz ADDRESS Winfield, Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07599

7601

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 2, 9, FilmG185 6-22-55 et Items 8,9, FilmG185 8-26-55 et

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg Baltimore City
STREET ADDRESS (If rural, give location) Finksburg Nursing Home

3. NAME OF (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	REBECCA	Slade	HOSHALL	August	9	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Widowed	June 22, 1877 1872	80 93 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Glenncoe, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Henry Harrison Anderson	Elizabeth Slade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO		Mr. Edward M. Hoshall, 218 Hawthorne Road

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.1 Immediate cause	(a) Bronchial Pneumonia (Terminal)	24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic C.V. Disease	5 yrs.
	(c) Abdominal Mass (etiology undetermined)	6 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 22, 1954, to Aug. 9, 1955, that I last saw the deceased alive on August 9, 1955, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin E. Strobel	M.D.	Reisterstown, Md.	8/9/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 12, 1955	Woodlawn Cemetery	Woodlawn, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		Wm J. Tickner & Sons	Balto. 17, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07600

7612 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Caroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY 3V014
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville — LENGTH OF STAY (in this place)	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.	STREET ADDRESS (If rural give location) 1200 Valley St. #2

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Thomas (Last) Hudson
4. DATE OF DEATH: (Month) 8 (Day) 12 (Year) 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10-3-1892
9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months 10 Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Cashier
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert Hudson
14. MOTHER'S MAIDEN NAME: Anna Hudson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Little Sisters of the Poor 1200 Valley St. Balto. 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death
4-4-3X
Immediate cause (a) Acute Cardiac Failure
DUE TO Chronic Hypertensive C-V Disease
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18, 1955, to 8-12, 1955, that I last saw the deceased alive on 8-12, 1955, and that death occurred at 6:15 PM, from the causes and on the date stated above.
SIGNATURE Walter H. Sommerfeldt M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Aug 16/55 — NAME OF CEMETERY OR CREMATORY Mount Olivet — LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REGISTRAR 8-23-55 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Wiedefeld Geo. E. — ADDRESS Biddle St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07601

7585

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster
MARYLAND LENGTH OF STAY (in this place) 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 E. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 103 E. Main St.

3. NAME OF DECEASED (Type or Print): (First) C. (Middle) RAYMOND (Last) J ENKINS

4. DATE OF DEATH (Month) AUG. (Day) 1, (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-22-1889

9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Clerk

10B. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wesley Jenkins

14. MOTHER'S MAIDEN NAME: Eliza Jane Hartley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-3771

17. INFORMANT & ADDRESS: Burnell Jenkins, Manchester, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

1 = 1 hr
2 = 2-27-55

431X IMMEDIATE CAUSE (A) Cerebral hemorrhage

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Syphilis (cont.)

DUE TO (C) Hypertension (cont.)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-31-, 1955, to 8-1-, 1955, that I last saw the deceased alive on 7-31-, 1955, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE W. C. Jamuta M.D. ADDRESS Westminster Md DATE SIGNED 8-2-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

DATE THEREOF 8-4-1955

NAME OF CEMETERY ~~OR CREMATORY~~ Ebenezer

LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR 8-3-55

REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR C. M. Waltz, ADDRESS Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07602

CERTIFICATE OF DEATH

76 3 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Henryton
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland
STREET ADDRESS 22 X - 2 (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Richard (Middle) (Last) Johnson
4. DATE OF DEATH: (Month) 8 (Day) 2 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12-6-1906
9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months: Days IF UNDER 24 HRS Hours: Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Mill
11. BIRTHPLACE (State or foreign country): Miami, Florida
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: William Johnson
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-32-1995
17. INFORMANT & ADDRESS: Richard Johnson, Fruitland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
002X
Immediate cause (a) Cardiac insufficiency
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Far advanced bilateral pulmonary tuberculosis.
DUE TO
(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-25 ,1955, to 8-2- ,1955, that I last saw the deceased alive on 8-2-55, 19 , and that death occurred at 8:20 a.m., from the causes and on the date stated above.
SIGNATURE T. F. Leahy M.D (Degree or title)
ADDRESS Henryton, Maryland
DATE SIGNED 8-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF Aug 2/55
NAME OF CEMETERY OR CREMATORY Fruitland
LOCATION (City, town, or county) Wicomico Co (State) Md
DATE REC'D BY LOCAL REGISTRAR 8-2-55
REGISTRAR'S SIGNATURE Elliott A Swarthout
24. FUNERAL DIRECTOR J. B. Johnson Sons
ADDRESS Hebron Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (7603)

* 7694

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 2/24/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY -
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 245 Dallas Court ✓

3. NAME OF DECEASED: (Type or Print) (First) Zach (Middle) Alexander (Last) JOHNSON

4. DATE OF DEATH: (Month) August (Day) 12 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): separated

8. DATE OF BIRTH. October 26, 1881

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch repairman

10B. KIND OF BUSINESS OR INDUSTRY: Watch

11. BIRTHPLACE (State or foreign country): Lynchburg, Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joe Johnson

14. MOTHER'S MAIDEN NAME. Clara Trent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X

IMMEDIATE CAUSE (A) Carcinoma of Stomach with metastases to liver and lung — INTERVAL BETWEEN ONSET AND DEATH about 6 mo

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with Cerebral arteriosclerosis 6 yrs

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —

21C WHERE DID (City or town) (County) (State) INJURY OCCUR? —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.

21E INJURY OCCURRED While ☐ at work Not while ☐ at work —

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July 22, 1950 to Aug. 12, 1955 that I last saw the deceased alive on Aug. 12, 1955, and that death occurred at 2:15 PM, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M.D. ADDRESS Sykesville, Maryland DATE SIGNED 8/12/55

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Aug. 15, 1955 | NAME OF CEMETERY OR CREMATORY St. Paul's | LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 13, 1955 | REGISTRAR'S SIGNATURE C. Harvey Wood

24. FUNERAL DIRECTOR Wm. Cook, Inc. ADDRESS 1217 Eutaw Pl.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7604

7605

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (In this place) 3Y 10M 28 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Amy (Middle) Matrona (Last) JONES

4. DATE OF DEATH: (Month) 8/ (Day) 18 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married | 8. DATE OF BIRTH: 9/7/81 | 9. AGE last birthday: 73 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Montgomery Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rufus F. King
14. MOTHER'S MAIDEN NAME: Ursala King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Chronic myocardial infarction DUE TO — month

(C) pulmonary edema and bronchopneumonia — hours

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction — 5 years

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/16, 1955 to 8/18, 1955, that I last saw the deceased alive on 8/17, 1955, and that death occurred at 12:15 AM DST, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt, M. D. ADDRESS Sykesville, Maryland DATE SIGNED 8/18/55

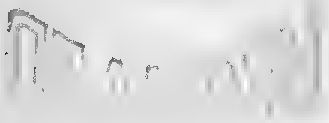
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Aug. 21, 1955 | NAME OF CEMETERY OR CREMATORY Damascus | LOCATION (City, town, or county) (State) Damascus, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 19, 1955 | REGISTRAR'S SIGNATURE C. Stacey Wilson | 24 FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53



7606 07605

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No: 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 40 y 11 m 18
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 3333 N. Charles Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	J.	Kidd	8	26	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	single	MAY 25, 1875	80 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
clerk		Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George Kidd	Mary Crane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	NONE	Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause 9367	(a) DUE TO Pulmonary embolism	hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Bronchopneumonia, beginning	hours
	(c) Fracture dislocation, left shoulder	14 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Mental deficiency without Psychosis	40 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY ward ?	21c. (City or town, (County) (State)	
		Sykesville, Carroll	Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
8 - 12 - 55 ? M.		pt. was found to have bruises all over his arm and chest, unable to move left arm

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Thank M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 8/29/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8/29/55	NEW CATHEDRAL	BALTIMORE MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-29-55	Dora Hedrick	CHARLES F. EVANS & SON	168 W. MT. ROYAL AVE

7697

MARYLAND STATE DEPARTMENT OF HEALTH

07606

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Taneytown | LENGTH OF STAY (In this place) 1/2 Years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester
STREET ADDRESS (If rural, give location) 20 Gerrard St.

3. NAME OF DECEASED (Type or Print): (First) RICHARD (Middle) (Last) KNOTT
4. DATE OF DEATH: (Month) Aug (Day) 19 (Year) 1955

5. SEX: M. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 1-25-11 | 9. AGE last birthday: 8 yrs. | If under 1 year: Months 6, Days 25 | If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Valley Feed Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: (First name unknown) Knott
14. MOTHER'S MAIDEN NAME: Anna Susan Reilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 218-01-7294
17. INFORMANT AND ADDRESS: Mrs. Anna Highberger Sharpsburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 331X Cerebral Hemorrhage — Interval between onset and death: 15 Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
James J. Thorsch, Deputy Medical Examiner, Hagerstown, Md. 8/19/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Aug. 22-55 | NAME OF CEMETERY OR CREMATORY Mt. View Cemetery | LOCATION (City, town, or county) (State) Sharpsburg Md.

DATE REC'D BY LOCAL REG. Aug. 21 1955 | REGISTRAR'S SIGNATURE Ethel M. Mathias | 24. FUNERAL DIRECTOR Edith V. Leaf | ADDRESS Williamsport Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

7698

CERTIFICATE OF DEATH

07607

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester — LENGTH OF STAY (In this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) MARTHA (Middle) E-HAPE (Last) LEESE

4. DATE OF DEATH: (Month) aug (Day) 21 (Year) 1955

5. SEX: F — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W. — 8. DATE OF BIRTH: July 26 1864 — 9. AGE last birthday: 91 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — 10b. KIND OF BUSINESS OR INDUSTRY: Hsk. — 11. BIRTHPLACE (State or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: George Bumblitz — 14. MOTHER'S MAIDEN NAME: Elizabeth alban

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: no — 17. INFORMANT: Mrs Howard Clas - Manchester Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
450.2 Immediate cause	(a) Recutitus ulcers	1 month
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) fracture rt hip - Pathological fractures rt femur & left tibial + fibula	3 yrs 2 months
	(c) Arteriosclerosis generalized	5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 8, 1951, to Aug 21, 1955, that I last saw the deceased alive on 7/23, 1955, and that death occurred at 9:40 p m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

W. H. Howard — M.D. — Manchester, Md — 8/22/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug 24-1955 — NAME OF CEMETERY OR CREMATORY: Union Rem — LOCATION (City, town, or county) (State): Balto Co Md

DATE REC'D BY LOCAL REG.: Aug 22-55 — REGISTRAR'S SIGNATURE: Mrs W F Denner — 24. FUNERAL DIRECTOR — ADDRESS: Edw A Tipton Hampstead Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07608

7609 **CERTIFICATE OF DEATH** Reg. Dist. No. ....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1y.11m.7days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 3 V 0 1-4 210 N. Madeira St. Baltimore 31. √

3. NAME OF DECEASED: (Type or Print) (First) Winfield (Middle) Samuel (Last) Leonard

4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1955 19

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed | 8. DATE OF BIRTH. Jan 6 1875 | 9. AGE last birthday 80 yrs. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ambrose Leonard | 14. MOTHER'S MAIDEN NAME: ? unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT & ADDRESS: Mrs. Henrietta Thomas (daughter) 210 N. Madeira St. Baltimore 31

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
430.0 IMMEDIATE CAUSE	(A) Myocardial infarction	days
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (B) Coronary Thrombosis	days
	DUE TO (C) Arteriosclerosis Heart disease.	years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma Prostate with bone metastases years; Chronic Brain syndrome with Psychotic reaction years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23- , 1955 , to 8-30- , 1955 , that I last saw the deceased alive on 8-30- , 1955 , and that death occurred at 8.10p M, from the causes and on the date stated above.

SIGNATURE Walther H. Bonnenfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 8-30-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried | DATE THEREOF Sept 2/55 | NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | LOCATION (City, town, or county) Baltimore (State)

DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. UNDERTAKER Philip Henry Sons | ADDRESS 201 Eutaw St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07609

7610 CERTIFICATE OF DEATH Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Pleasant Valley
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster, Md. R.D. 7

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Pleasant Valley
STREET ADDRESS (If rural give location) Westminster, Md. R. D. 7

3. NAME OF DECEASED: (Type or Print) (First) Missouri (Middle) N. (Last) Leppo

4. DATE OF DEATH: (Month) 8/6/55 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 11/2/1871

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife, Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Keefer

14. MOTHER'S MAIDEN NAME: Elizabeth Rodkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs H. M. Warehime
Mrs. H. M. Warehime, Westminster, Md. R.D.7

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Cardiac Decompensation — Interval Between Onset And Death: 2 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Cardio. Renal Vascular disease — 6 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-/- ,1955, to 8-6- , 1955, that I last saw the deceased alive on 8-5- , 1955, and that death occurred at 3:30 P.M. , from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas. R. Foutz M.D. ADDRESS Westminster Md DATE SIGNED 8-8-'55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/9/55 NAME OF CEMETERY OR CREMATORY St. Marys Union Cemetery LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.

DATE REC'D BY LOCAL REGISTRAR 8-8-55 REGISTRAR'S SIGNATURE Hamil Weiler

24. FUNERAL DIRECTOR J. W. Littlestown, Littlestown, Pa. ADDRESS
R. A. Lottle Partner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07610

7611 CERTIFICATE OF DEATH Reg. Dist. No. . . . . .

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: Springfield State Hospital
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 4 months 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: 081
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster X
STREET ADDRESS (If rural give location) Route 6 Westminster, Md.

15

3. NAME OF DECEASED: (Type or Print) (First) Marian (Middle) [illegible] (Last) Mac Gill

4. DATE OF DEATH: (Month) August (Day) 6 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-14-1883

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Horn

14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Black

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Howard Mac Gill (husband) Rt.6, Westminster, Md. Miss Elizabeth Mac Gill (daughter) 4811 Gwynn Oak Ave. Balt. 7, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 491X (a) Bronchopneumonia — Interval Between Onset And Death: 3 3days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) [illegible]

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. associated with circulatory disturbances, with cerebral arteriosclerosis. Psychosis, Diabetis Mellitus. Years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1955, to 8-6-, 1955, that I last saw the deceased alive on 8-6-, 1955, and that death occurred at 6.45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or Title) W. H. Tonnemacher M.D ADDRESS Springfield State Hospital. DATE SIGNED August 6-55.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF August 9, 1955 NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery LOCATION (City, town, or county) (State) Woodlawn, Maryland

DATE REC'D BY LOCAL REGISTRAR 8-8-55 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Ellsworth Armacost ADDRESS Ellsworth Armacost 4600 Liberty Heights Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

07611

7612

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (In this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural, give location) Memorial Blvd. East, P.O. Box 764

3. NAME OF DECEASED (Type or Print): (First) HALSIE (Middle) LOUISE (Last) MARSHALL

4. DATE OF DEATH: (Month) 8 (Day) 11 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 6-12-32

9. AGE last birthday: 23 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): College Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Marshall

14. MOTHER'S MAIDEN NAME: Halsie Leona Rife

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 974X Suffocation — Interval Between Onset and Death: Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hanging by the neck

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenic reaction, chronic undifferentiated type — 1 year & longer

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY [illegible] — (CITY OR TOWN) Sykesville — (COUNTY) [illegible] — (STATE) Md

TIME OF INJURY (Month) 8 (Day) 11 (Year) 55 (Hour) 10 P.M.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Hanging himself

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE [illegible] (Degree or title) Deputy Medical Examiner — ADDRESS [illegible] Md — DATE SIGNED 8-12-55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF 8/15/1955 — NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY — LOCATION (City, town, or county) (State): HAGERSTOWN, MARYLAND

DATE REC'D BY LOCAL REG. Aug. 12, 1955 — REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR: C.M. SUTER AND SONS — ADDRESS: HAGERSTOWN MD

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7613 **CERTIFICATE OF DEATH** 07612

Reg. Dist. No. 75

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH. COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Union Bridge (Rural)
LENGTH OF STAY (in this place) 32 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS oo

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge, Rural X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) ISAAC (Middle) ANDERSON (Last) McINTURFF
4. DATE OF DEATH: (Month) Aug (Day) 15 (Year) 19 55

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH: March 25 - 1871 | 9. AGE last birthday 84 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thos S. McInturff
14. MOTHER'S MAIDEN NAME: Ann Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-16-3974
17. INFORMANT & ADDRESS: Mrs Chas Ebhart. Union Bridge Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2.21X

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertension — 5 yrs

DUE TO (C) Arteriosclerosis — 5 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1949, to Aug 18., 1955, that I last saw the deceased alive on Aug. 17., 1955, and that death occurred at 3:30 PM, from the causes and on the date stated above.

SIGNATURE W N Hoard M.D ADDRESS Manchester Md DATE SIGNED Aug 19-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug 21/55
NAME OF CEMETERY OR CREMATORY Lutheran
LOCATION (City, town, or County) (State) Keymar Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 19/55
REGISTRAR'S SIGNATURE Mrs. Wm. Demmer
24. FUNERAL DIRECTOR Edw C. Upton, Hampstead Md ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07613

7614 CERTIFICATE OF DEATH Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1 PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
MARYLAND LENGTH OF STAY (in this place) 2 y 2 m 15 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hopital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 18, Md.
STREET ADDRESS (If rural give location) 914 Bonaparte Avenue

3. NAME OF DECEASED: (Type or Print) (First) Mary Elizabeth Mc Namara (Middle) ~~Elizabeth~~ ~~Mary~~ (Last) Mc Namara

4. DATE OF DEATH: (Month) 8 (Day) - 20 - (Year) 1955

5 SEX: F | 6 COLOR OR RACE: W | 7 SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed | 8 DATE OF BIRTH: January 14th--? unknown | 9. AGE last birthday 83 ? yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mose Duval
14. MOTHER'S MAIDEN NAME: Harriett Trembley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (No) (If Yes, give war or dates of service) None
16 SOCIAL SECURITY NO unkn
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chron.brain syndr. ass.with changes of growth senile brain disease with psych.reaction — years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-16- , 1954, to 8 - 20-, 1955, that I last saw the deceased alive on 8-19- , 1955, and that death occurred at 4 :A M, from the causes and on the date stated above.

SIGNATURE Edmund Leuthaus M. D. ADDRESS Springfield State Hospital DATE SIGNED Aug.20, 1955

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8-22-1955 | NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | LOCATION (City, town, or county) (State) Edmondson Ave.Balto:Md.

DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24 FUNERAL DIRECTOR George J.Ruth Inc. ADDRESS 1735 Harford Avenue

George J Ruth Inc H&D

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07614

7615 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville — LENGTH OF STAY (in this place) 35 years	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital	STREET ADDRESS (If rural give location) 1606 Hanover Street
3. NAME OF DECEASED (Type or Print): (First) Louise (Middle) (Last) Meredith	4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
F	N	Single	Unknown	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Hand	10b. KIND OF BUSINESS OR INDUSTRY: Unk.	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ? Meredith		14. MOTHER'S MAIDEN NAME: Not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT & ADDRESS: Hospital Record	

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — 420.1 IMMEDIATE CAUSE	(A) Coronary Occlusion	Minutes
ANTECEDENT CAUSE (S) — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Hypertensive cardiovascular [illegible]	20 years & longer
	DUE TO (C) [illegible]	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	[illegible]	35 years & longer

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-17, 1920, to 8-4, 1955, that I last saw the deceased alive on 8-4, 1955, and that death occurred at 10:45 PM, from the causes and on the date stated above.

SIGNATURE Gertrud Sonnenfeld M.D. ADDRESS Springfield State Hospital Sykesville Md. DATE SIGNED 8-4-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-9-55	Mt Olivet	Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 6, 1955	C. Harry Ward	John H. [illegible] Inc.	Light & Montgomary Sts.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7616 CERTIFICATE OF DEATH

07615

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A1E

1. PLACE OF DEATH:

COUNTY: Carroll — STATE: MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville

LENGTH OF STAY (in this place): 29½ years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY:

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 3 x 3 1-4

STREET ADDRESS (If rural give location): Unk.

3. NAME OF DECEASED (Type or Print): (First) GERTRUDE (Middle) E. (Last) MILLER

4. DATE OF DEATH: (Month) August (Day) 5 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1873

9. AGE last birthday: 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Oliver Ewing

14. MOTHER'S MAIDEN NAME: Alice Henkle

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Cerebral Hemorrhage	2 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Arteriosclerosis, general	Years
	(c) DUE TO Tuberculosis of lung - far advanced - inactive	2 years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Dementia Praecox, paranoid type. — 30 yrs.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-13 ..,1953, to 8-5, 1955, that I last saw the deceased alive on 8-5-, 1955, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter T. Townsend — ADDRESS: Springfield State Hospital — DATE SIGNED: 8-5-55

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 8-6-55 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): 1217 E. Fayette St. Balto. Md.

DATE REC'D BY LOCAL REGISTRAR: Aug. 6, 1955 — REGISTRAR'S SIGNATURE: C. Henry Lewis

24. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 E. Fayette St. Balto.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07616

7617 CERTIFICATE OF DEATH

Reg. Dist. No. 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruzillburg — LENGTH OF STAY (in this place) 65 yrs. — HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster R.D. 7

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruzillburg — STREET ADDRESS (If rural give location) Westminster R.D. 7

3. NAME OF DECEASED: (First) CLARENCE (Middle) H. (Last) MYERS

4. DATE OF DEATH: (Month) August (Day) 11, (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: NOV. 4 1889

9. AGE last birthday: 65 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farming Own farm

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles W Myers

14. MOTHER'S MAIDEN NAME: Clara Otto

15. WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Lula F. Myers

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: ½ hour

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 11 ..., 19 55, to Aug 11 ..., 19 55, that I last saw the deceased alive on Aug 11 ..., 19 55, and that death occurred at 11:10 AM (D.S.T.) from the causes and on the date stated above.

SIGNATURE (Degree or title): Julius Chepko M.D. — ADDRESS: Westminster Md — DATE SIGNED: Aug 12, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug 14 1955 — NAME OF CEMETERY OR CREMATORY: Bauer Cemetery — LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: 8-13-55 — REGISTRAR'S SIGNATURE: Hazel Miller

24. FUNERAL DIRECTOR: H. Bankard & Son — ADDRESS: Westminster, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

07617

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

7618

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Nr. Silver Run — LENGTH OF STAY (in this place): Few Hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Westminster, Md. R.D.1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Massachusetts — COUNTY: Suffolk
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Allston (Boston)
STREET ADDRESS (If rural, give location): 177 Cambridge Street

3. NAME OF DECEASED (Type or Print): (First) Elwood (Middle) Sterling (Last) Nusbaum
4. DATE OF DEATH: (Month) 8 (Day) 5 (Year) 19[illegible]

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
Male	White	Married	6/27/1918	37 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during greater part of life, even if retired): Serviced Televisions
10b. KIND OF BUSINESS OR INDUSTRY: T.V. Repair Shop
11. BIRTHPLACE (State or foreign country): Carroll Co., Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David S. Nusbaum
14. MOTHER'S MAIDEN NAME: Myrtle Weishaar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) Yes (If yes, give war or dates of service) World War 2
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs Geneva Nusbaum — 177 Cambridge St. Allston, Mass.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Coronary Occlusion — Interval between onset and death: Minutes
420.1
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James I. Marsh	Deputy Medical Examiner	Westminster Md	8/5/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/9/55	Baust Church Cemetery	Nr. Taneytown, Carroll Co. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-8-55	Hamer Miller	J. M. Little, Son — R. A. Little Partner.	Littlestown, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07618

CERTIFICATE OF DEATH

7619

Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural, Westminster
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Mills Westminster, Md. R. D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Carroll COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster X
STREET ADDRESS (If rural give location) Union Mills Westminster, Md. R. D. 1

3. NAME OF DECEASED: (Type or Print) (First) Leilia (Middle) Miraud (Last) Nusbaum
4. DATE OF DEATH: (Month) (Day) (Year) 8/17/55 19
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 11/21/1877
9. AGE Last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: School Teacher (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Nusbaum
14. MOTHER'S MAIDEN NAME: Mary Earhart

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: W. R. Nusbaum W. R. Nusbaum Taneytown, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

581.0
Immediate cause (a) Cirrhosis of liver
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) myocarditis (etc
DUE TO
(c) Nephritis (Ch)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 8, 19 55 to Aug 17, 19 55, that I last saw the deceased alive on Aug 16, 19 55, and that death occurred at 5:30 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) W. P. Jamison MD, ADDRESS Westminster Md DATE SIGNED 8-17-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8/20/55
NAME OF CEMETERY OR CREMATORY St. Marys Cemetery
LOCATION (City, town, or county) (State) Silver RUN, Carroll Co., Md

DATE REC'D BY LOCAL REGISTRAR 8-18-55
REGISTRAR'S SIGNATURE Harriet Miller
24. FUNERAL DIRECTOR J. M. Little & Son ADDRESS Littlestown, Pa.
Per P. A. Little - Partner.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07619

MARGIN RESERVED FOR BINDING

M

I

MARYLAND

7620

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Springfield State Hospital
COUNTY Carroll
MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Maryland.
LENGTH OF STAY (in this place) 6 yr, 7mth, 24dys
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY St.Mary's
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexinton Park 18X-2
STREET ADDRESS (If rural, give location) Lexinton Park

3. NAME OF DECEASED (Type or Print) (First) Ballard (Middle) (Last) Parks.

4. DATE OF DEATH (Month) August (Day) 6 (Year) 1955

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 7-8-1903

9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City employee-disposal operator

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Parks

14. MOTHER'S MAIDEN NAME Rebecca

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Unknown

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Infarction — days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis Heart disease — years

(c) Thrombosis of the Coronary artery — days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with C.N.S Syphilis. — years
Pulmonary Tuberculosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12-49, 19 , to 8-6- , 19 55, that I last saw the deceased alive on 8-6- 1955, and that death occurred at 9.40 a m., from the causes and on the date stated above.

SIGNATURE Walter H Tomingfield M.D. (Degree or title) ADDRESS

DATE SIGNED August 6-55

23. BURIAL, CREMATION REMOVAL (Specify) Embalmed
DATE Aug 11, 1955
NAME OF CEMETERY OR CREMATORY Univ. of Md. Med. Sch.
LOCATION (City, town, or county) Balto. (State) Maryland

DATE REC'D BY LOCAL REG. Aug 14, 1955

REGISTRAR'S SIGNATURE C. Harry Neary

24. FUNERAL DIRECTOR The Anatomy Board of Md.
ADDRESS
per: M. Christian

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (7620)

7621 CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Sykesville
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 2. Sykesville Streaker Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville X
STREET ADDRESS (If rural give location) Route 2 - Sykesville Streaker Road

3. NAME OF DECEASED: (Type or Print) (First) Blanche (Middle) Everett (Last) Pickett

4. DATE OF DEATH: (Month) (Day) (Year) August 17 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Jan. 18, 1894
9. AGE last birthday 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Augustus Riggs Bidinger
14. MOTHER'S MAIDEN NAME: Mary Henrietta Ritter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) No.
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT & ADDRESS: Myrtle G. Bidinger Finksburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Cerebral Hemorrhage	12 hours
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Hypertensive Cardiovascular Disease	6 years
	(C) DUE TO	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to August, 1955, that I last saw the deceased alive on August 16, 1955, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

SIGNATURE W.B. Culwell M. D. ADDRESS Mt. Airy, Md DATE SIGNED Aug. 17, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF 8-20-1955
NAME OF CEMETERY ~~OR CREMATORY~~ Poplar Springs
LOCATION (City, town, or county) (State) Howard Co., Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 18, 1955
REGISTRAR'S SIGNATURE Robert R. Hurst
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

7622

07621

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy — LENGTH OF STAY (in this place) 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) Hutchinson (Last) Pickles

4. DATE OF DEATH: (Month) Aug (Day) 25 (Year) 1955

5. SEX: F — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S — 8. DATE OF BIRTH: Feb 7 1884 — 9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg Nurse — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): England — 12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: William Henry Pickles — 14. MOTHER'S MAIDEN NAME: Mary Ann Hutchinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Gertrude H Pusey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension and (c) Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-23-, 1955, to 8-25-, 1955, that I last saw the deceased alive on 8-23-, 1955 and that death occurred at 2 a m, from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

C M VanPoole M.D. Mt Airy Md 8-25-55

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State)

Buried 8/29/55 — Rock Creek Cem — Washington D C

DATE REC'D BY LOCAL REG. Aug 25, 1955 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS

14th [illegible] Funeral Service, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07623

7623

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6 mo, 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY C. Ty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 12 3 Yrs 1 4
STREET ADDRESS (If rural give location) 1624 Waverly Way

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) Economy (Last) Prempas
4. DATE OF DEATH: (Month) 8 (Day) 6 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: 1870
9. AGE last birthday 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A. Naturalized
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Acute myocardial infarction — minutes

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Acute coronary occlusion — minutes

DUE TO (C) Hypertensive cardiovascular disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. C.B.S. due to cerebral arterio-sclerosis — years

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/4, 1955, to 8/6, 1955 that I last saw the deceased alive on 8/6, 1955, and that death occurred at 3:45 P M, from the causes and on the date stated above.
SIGNATURE Gertrude M. Gross, M.D. M.D. ADDRESS Sykesville, Md DATE SIGNED 8/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-10-55
NAME OF CEMETERY OR CREMATORY Chicago
LOCATION (City, town, or county) (State) Chicago, Ill.

DATE REC'D BY LOCAL REGISTRAR Aug. 7, 1955
REGISTRAR'S SIGNATURE C. Henry Tilden
24. FUNERAL DIRECTOR Wm. Cook Jr.
ADDRESS 120 Uhler Ave. Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07623

7586 CERTIFICATE OF DEATH Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) about 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 S. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 112 S. Green St.

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) (Last) REED

4. DATE OF DEATH: (Month) Aug. (Day) 12 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: July 18, 1873

9. AGE last birthday 82 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Board of Education

11. BIRTHPLACE (State or foreign country) Sandyhook Carroll Co, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Reed

14. MOTHER'S MAIDEN NAME: Mary Essig

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Floyd Spencer, Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) ... Coronary occlusion & Myocardial Infarction DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ... Arteriosclerosis DUE TO

(c)

Interval Between Onset And Death: 7 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 11, 1955, to Aug 12, 1955, that I last saw the deceased alive on Aug. 12, 1955, and that death occurred at 5:25 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) James J. Monk M.D.

ADDRESS Westminster Md

DATE SIGNED 8/12/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Aug. 15, 55

NAME OF CEMETERY OR CREMATORY Lewistown Cemetery

LOCATION (City, town, or county) (State) Rural, Westminster Md.

DATE REC'D BY LOCAL REGISTRAR 8-14-55

REGISTRAR'S SIGNATURE Harriet Ambler

24. FUNERAL DIRECTOR J. S. Myers Jr. Westminster Md.

ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07624

CERTIFICATE OF DEATH

7624 Reg. Dist. No.

1. PLACE OF DEATH: Carroll
COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville Md.
LENGTH OF STAY (in this place) 28 y
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3 W c 1-4
STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) L. (Last) Rider
4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		5-12-93	61 62 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Anne Arundel County
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George H. Rider
14. MOTHER'S MAIDEN NAME: Cora Seylert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
410X IMMEDIATE CAUSE	(A) Coronary Occlusion	None
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Mitral Stenosis + Insufficiency DUE TO	about 20 yrs
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Leukopenia		28 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1927, to 8-4, 1955, that I last saw the deceased alive on 8-4, 1955, and that death occurred at 8:30 P.M, from the causes and on the date stated above.

SIGNATURE Martin Ross M.D. M.D. ADDRESS Sykesville, Md. DATE SIGNED August 5-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF Aug. 8 1955
NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY
LOCATION (City, town, or county) (State) BALTIMORE, CITY MARYLAND

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
FUNERAL DIRECTOR Charles Dumoreau
ADDRESS 4510 Liberty Hghts Avenue

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07625

7625

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural, Westminster
LENGTH OF STAY (in this place) 2 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 93 Meadow View Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 83 W Green St.

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) RICHARDS (Last) RIDINGTON

4. DATE OF DEATH: (Month) Aug (Day) 9 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 5, 1865

9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Preacher

10b. KIND OF BUSINESS OR INDUSTRY: Methodist

11. BIRTHPLACE (State or foreign country): England (Cornwall)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Jeremiah Ridington

14. MOTHER'S MAIDEN NAME: Phillis Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Dr. Wm. R. Ridington, Westminster Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Arteriosclerosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to Aug 9, 1955, that I last saw the deceased alive on Aug 9, 1955, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

SIGNATURE James J. Moser (Degree or title) M.D ADDRESS Westminster Md DATE SIGNED 8/10/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug 13/55 NAME OF CEMETERY OR CREMATORY Prospect Cemetery LOCATION (City, town, or county) Mansfield, Penna. (State)

DATE REC'D BY LOCAL REGISTRAR 8-11-55 REGISTRAR'S SIGNATURE Harold C. Miller

24. FUNERAL DIRECTOR J. S. Rogers Jr ADDRESS Westminster Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07627

7626

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister (Rural)
LENGTH OF STAY (in this place) 17 mon
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE ~~Maryland~~ Pa. COUNTY ~~Carroll~~ York
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Wm~~ Glenrock 06X-1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Agnes (Last) Siegman

4. DATE OF DEATH: (Month) Aug (Day) 19 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 14-1863

9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Carroll Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Rinehart

14. MOTHER'S MAIDEN NAME: Mandilla Herbst

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Clayton Siegman Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause (a) 331X	Cerebral Hemorrhage	4 days
DUE TO (b) Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	Hypertension	1 yr.
DUE TO (c)	Arteriosclerosis	5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1955, to Aug 19, 1955, that I last saw the deceased alive on Aug 18, 1955, and that death occurred at 4 A.M., from the causes and on the date stated above.

SIGNATURE W. H. Foard (Degree or title) M.D. ADDRESS Manchester, Md DATE SIGNED 8/19/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug. 21, 1955 NAME OF CEMETERY OR CREMATORY Stone Church LOCATION (City, town, or county) (State) Brodbecks R.D. York Co. Pa.

DATE REC'D BY LOCAL REGISTRAR Aug 19-55 REGISTRAR'S SIGNATURE Mrs. W. S. Denner

24. FUNERAL DIRECTOR Geo. E. Kiefle ADDRESS Glen Rock, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07623

7627

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS. A15

1. PLACE OF DEATH:

COUNTY: CARROLL — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville

LENGTH OF STAY (in this place): 10 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Washington

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sharpsburg

STREET ADDRESS (If rural give location): none

3. NAME OF DECEASED: (Type or Print) (First) CTHO (Middle) JAMES (Last) SMITH

4. DATE OF DEATH: (Month) 8 (Day) 11 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: unknown

9. AGE last birthday: 79? yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): USA- Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Otho Smith

14. MOTHER'S MAIDEN NAME: Ann — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk - (If Yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk -

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

59 2X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 8 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertensive cardiovascular disease — years

DUE TO

(c) Chronic nephritis, uremia — 2 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction — unknown

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3 ,19 5 , to 8/11 , 19 55 , that I last saw the deceased alive on 8/11 , 19 55 and that death occurred at 3:45 PM DST from the causes and on the date stated above.

SIGNATURE (Degree or title) W. T. Tomlinson M.D. — ADDRESS Sykesville, Maryland — DATE SIGNED 8/11/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 8/13/55 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem — LOCATION (City, town, or county) (State): Hagerstown Md

DATE REC'D BY LOCAL REGISTRAR: Aug. 12, 1955 — REGISTRAR'S SIGNATURE: C. Harry Eberly

24. FUNERAL DIRECTOR — ADDRESS: F K Coffman Hagerstown Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7628 CERTIFICATE OF DEATH

Reg. Dist. No. 07624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville
LENGTH OF STAY (in this place) 2 Y, 11M, 6 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland - Washington COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown 21.02-2
STREET ADDRESS (If rural give location) 230 Alexander Street ✓

3. NAME OF DECEASED: (Type or Print) (First) IVY (Middle) MYRTLE (Last) SPRANKLE

4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: 2/10/81

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Augustus Sprankle

14. MOTHER'S MAIDEN NAME: Laura Sprankle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral thromboxis — Interval Between Onset And Death: 3 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — years?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/18 ..., 1955..., to 8/4 ..., 1955, that I last saw the deceased alive on 8/4/..., 1955, and that death occurred at 8:15 AM DST from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H Sonnenfeld M D ADDRESS Springfield State Hospital DATE SIGNED 8/4/55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF 8/6/55 — NAME OF CEMETERY OR CREMATORY Brookside — LOCATION (City, town or county) Near Hagerstown (State) Md

DATE REC'D BY LOCAL REGISTRAR Aug. 5, 1955 — REGISTRAR'S SIGNATURE C Harry Weir

24. FUNERAL DIRECTOR F K Hoffman — ADDRESS Hagerstown Md

7629

07630 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville

LENGTH OF STAY (in this place) 17Y 9M 22D

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS (If rural, give location) 10 N. Lee Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
MARY	EDITH	STEGMAIER	8	19	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	W	single	6/29/93	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
none	None	Allegany County, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Ignatius Stegmaier	Catherine Matt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
Unk.	—	Unk.	Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Hyperpyrexia	24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Toxemia	4 days
	DUE TO (c)	Fracture of right hip	30 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Mental deficiency — 62 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
Aug 9 – 55	subcapital fracture of right femur.	Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	Ward, Hospital	Sykesville	Carroll	Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
7	20	55	P.M.			patient stumbled over another patients feet and fell to floor

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Mason M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 8/19/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-22-55	Rose Hill	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 20, 1955	C. Harry Eckel	Vincent A. Mangelli	Cumberland, Md.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07631

7630

CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Taneytown
LENGTH OF STAY (in this place) 18 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springf. Hall Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkton
STREET ADDRESS (If rural give location) 403 North Point Rd. ✓

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) Josephine (Last) Stormer

4. DATE OF DEATH. (Month) (Day) (Year) 7 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)

8. DATE OF BIRTH: 3-11-85

9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): [illegible] U.S.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry C. Miller

14. MOTHER'S MAIDEN NAME: Mary McKenna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —

16. (If Yes, give war or dates of service) —

17. SOCIAL SECURITY NO. ✓

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE

(A) Coronary [illegible]

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(B) Coronary; Artery [illegible]

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH [illegible] Death

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-28, 1937, to 8-7, 1955, that I last saw the deceased alive on 8-6, 1955, and that death occurred at 9 a M, from the causes and on the date stated above.

SIGNATURE [illegible] M.D. ADDRESS [illegible] DATE SIGNED 8-1-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8/11/55

NAME OF CEMETERY OR CREMATORY New Cathedral Cem.

LOCATION (City, town, or county) (State) 4300 Old Frederick Rd.

DATE REC'D BY LOCAL REGISTRAR [illegible]

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR John J. Emmanuel Sr.

ADDRESS Ellicott

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07633

7631 CERTIFICATE OF DEATH Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): X Rural, Nr. Westminster
MARYLAND LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00 Westminster, Md. R. D. 3

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westminster X
STREET ADDRESS (If rural give location): Westminster, Md. R. D. 3 1

3. NAME OF DECEASED: (Type or Print) (First) Milton (Middle) Wesley (Last) Swenk

4. DATE OF DEATH: (Month) 8/5/55 (Day) (Year) 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb. 10, 1873

9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Farming, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Own farm.

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Swenk

14. MOTHER'S MAIDEN NAME: Susan Bachman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Malcolm Stewart Westminster, Md. R-3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH,

Immediate cause — (a) Arteriosclerosis generalized — Interval Between Onset And Death: 10 yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (a) with cerebral & coronary failure — 3 yrs.

(b) Nephritis chronic — 1 yr.

DUE TO (c) Anemia — 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19 55, to Aug., 19 55, that I last saw the deceased alive on Aug 3, 19 55, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Rev. E. Thomassy M.D. Hanover 8-5-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 8/8/55

NAME OF CEMETERY OR CREMATORY: Bachmans Valley Cemetery

LOCATION (City, town, or county) (State): Nr. Westminster Carroll Co, Md.

DATE REC'D BY LOCAL REGISTRAR: 8-8-55

REGISTRAR'S SIGNATURE: Wanda Miller

24. FUNERAL DIRECTOR: J. M. Little & Son

ADDRESS: Littlestown, Pa.

By R. A. Little Partner.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07634

Items 4,9, FilmG185 8-22-55 et

7632

CERTIFICATE OF DEATH

Reg. Dist. No. 12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 8 m 14 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington 15X-2
STREET ADDRESS (If rural give location) 5013 Strathmore Ave. ✓

3. NAME OF DECEASED: (Type or Print) (First) OSCAR (Middle) (Last) TABLER

4. DATE OF DEATH: (Month) August (Day) 12, (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11-4-81

9. AGE last birthday: 73 YRS. 11 MO. 4 DA.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Tabler

14. MOTHER'S MAIDEN NAME: Ida Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT & ADDRESS: Mrs. Edith Tabler--wife 5013 Strathmore Ave., Kensington

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Cerebral hemorrhage — Interval Between Onset And Death: 5 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertens. cardiovasc. disease — years

DUE TO (c) C.B.S. of unknown or unspecified cause with psychotic reaction — 1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's disease — years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT (Specify) / SUICIDE / HOMICIDE: accid.

PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.): yard

(CITY OR TOWN): Sykesville (COUNTY): Carroll (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): about 6/20/55 m.

INJURY OCCURED While at Work ☒ Not While At Work ☐

HOW DID INJURY OCCUR? on or about yard, details unkn.

22. I hereby certify that I attended the deceased from 11-24-55 to 8-12-55, that I last saw the deceased alive on 8-12-55, and that death occurred at 11:20 PM from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter H. Sommerfeldt M.D. — ADDRESS: Spr. St. Hosp. — DATE SIGNED: 8/12/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug. 5 1955 — NAME OF CEMETERY OR CREMATORY: Fort Lincoln — LOCATION (City, town, or county) (State): Bladensburg Road, Md.

DATE REC'D BY LOCAL REGISTRAR: 8/12/55 — REGISTRAR'S SIGNATURE: A. Fanny Mears

24. FUNERAL DIRECTOR: Robt C. Dempsey - Bellside - Md. — ADDRESS:

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07635

7633 CERTIFICATE OF DEATH Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marston
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS New Windsor Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marston
STREET ADDRESS (If rural give location) New Windsor Rural

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) NAYLOR (Last) TOWNSHEND
4. DATE OF DEATH: (Month) Aug. (Day) 30 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 9/28/1879
9. AGE Last birthday: 75 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Farmer retired
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H Townshend
14. MOTHER'S MAIDEN NAME: Julia Naylor

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Martha Townshend, New Windsor, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 4 hrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis - Rheumatic
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1955, to Aug 30 1955, that I last saw the deceased alive on Aug 28, 1955, and that death occurred at 5 P.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) J. H. Legg M.D. ADDRESS Union Bridge DATE SIGNED 8-31-55

23. BURIAL, CREMATION, REMOVAL (Specify) Buried DATE THEREOF 9/2/55 NAME OF CEMETERY OR CREMATORY Westminster Cem. LOCATION (City, town, or county) Westminster (State) Md.
DATE REC'D BY LOCAL REGISTRAR Aug 31/55 REGISTRAR'S SIGNATURE Essie S Benedict
24. FUNERAL DIRECTOR C. O. Stambler & Sons ADDRESS New Windsor, Md.

VS. A15